

FILED SEP 24 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29553**

BIRTH NO. **55573-41** REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **3010**

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Cape Girardeau</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Cape Girardeau</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Cape Girardeau</b>	
c. LENGTH OF STAY (in this place) <b>2 days</b>		d. STREET ADDRESS (If rural, give location) <b>Spanish Street</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Cape Osteopathic Hosp.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>JEAN</b>	b. (Middle) <b>IDA</b>	c. (Last) <b>TILLEY</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept 9, 1949</b>
--	------------------------	-------------------------	---

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>SEPT 7 1949</b>	9. AGE (In years last birthday) <b>2</b>	IF UNDER 1 YEAR Months <b>2</b> Days	IF UNDER 1 HR. Hours <b>2</b> Min.
----------------------	-------------------------------	--	--	--	---	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTH PLACE (State or foreign country) <b>Cape Girardeau, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
---	---	---	--

13a. FATHER'S NAME <b>Joseph W. Tilley</b>	13b. MOTHER'S MAIDEN NAME <b>Olivera Knapheide</b>	14. NAME OF HUSBAND OR WIFE
--	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Joseph W. Tilley</b>	ADDRESS <b>Advanee, Mo.</b>
---	-------------------------------------	---	-----------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Premature (5 1/2 months)</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS - <b>Not sufficiently developed</b>		Conditions contributing to the death but not related to the disease or condition causing death. <b>to take measurement</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **Sept 7, 1949**, to **Sept 9, 1949**, that I last saw the deceased alive on **9-9, 1949**, and that death occurred at **1 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>E. C. Masters, M.D.</b> (Degree or title)	23b. ADDRESS <b>Advanee, Mo.</b>	23c. DATE SIGNED <b>Sept 9, 1949</b>
---	----------------------------------	--------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>Sept 9, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Morgan Memorial Park</b>	24d. LOCATION (City, town, or county) (State) <b>Advanee, Missouri</b>
---	-------------------------------	--	--

DATE REC'D BY LOCAL REG. <b>9-14-1949</b>	REGISTRAR'S SIGNATURE <b>C. C. Summers</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Loy S. Morgan</b>	ADDRESS <b>Advanee, Mo.</b>
---	--	---	-----------------------------

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

16-4

RECEIVED 9-19-49

Health Officer No. 4

File Number 949-12

led

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

*Not Embalmed*

Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed *William H. Morgan*

Licensed Embalmer No. *4640*

P. O. Address *Adams, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.